DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OFFICIAL FILE COPY

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 1

2. STATE: OKLAHOMA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01-01-03

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.70

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ -0-
b. FFY 2004 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Page 3a-2

(Explanation)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same Page, Revised 02-01-01, TN#01-07

Oklahoma 03-011
approved: 04/04/03
effective: 01/01/03

10. SUBJECT OF AMENDMENT:

Removing prior authorization requirement from Home Health services.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mike Fogarty

14. TITLE:
Chief Executive Officer

15. DATE SUBMITTED:
1-15-03

16. RETURN TO:
Oklahoma Health Care Authority
Attn: Billie Wright
4545 N. Lincoln, Suite 124
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
22 JANUARY 2003

18. DATE APPROVED:
4 APRIL 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 JANUARY 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
ANDREW A. FREDRICKSON

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID

23. REMARKS:
c: Mike Fogarty
Jim Hancock
Billie Wright

FORM HCFA-179 (07-92)

Instructions on Back

State: OKLAHOMA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

8. Home Health Services

After January 1, 1998, all Home Health Agencies requesting an initial Medicaid provider agreement with this Agency must meet the capitalization requirements as set forth in 42 CFR 489.28.

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Home health services are provided in the patient's residence to categorically needy individuals. Such services are compensable to a home health agency or when no such agency exists, payment is made to a registered nurse who is currently licensed to practice in the state, received written orders from the patient's physician, documents the care and service provided and has had acceptable training for clinical and administrative record keeping from a health department nurse. Payment is made for any combination of home health visits not to exceed 36 visits per year.

b. Home health aid services provided by a home health agency.

Payment is made on behalf of eligible individuals for any combination of home health visits and home health aid visits not to exceed 36 visits per year.

c. Medical supplies, equipment and appliances suitable for use in the home.

Standard medical supplies: defined as those disposable items which are used for the care and treatment of a medical condition, are medically necessary, and are prescribed by the appropriate medical provider. (Items not covered include but are not limited to: diapers, underpads, medicine cups, eating utensils and personal comfort items.)

Equipment and appliances that are medically necessary, suitable for use in the home or workplace, that can withstand repeated use, are used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, are provided on a rental basis, if the period of use is no longer than 10 months or less (except oxygen and other respiratory equipment). Purchase of equipment is covered when anticipated length of use exceeds 10 months. Rental of hospital beds, support surfaces, wheelchairs, continuous positive airway pressure devices and lifts requires prior authorization. Purchase of equipment with a fee schedule price of $500.00 or more requires prior authorization.